The Business Council
of Fairfield County

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Testimony on Bill Number 1045- An Act Concerning Responsibility for Hospital "Never" Events

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Every day someone is harmed by the health care system intended to help him or her. Medical errors are one of the Nation's leading causes of death and injury and Connecticut lacks an effective system for measuring and addressing these errors.

While most Americans believe that our health care system is the best in the world, a number of studies indicate that Americans receive less than optimal care.[1] According to recent studies, U.S. adults receive about half of the recommended health care services.[2]

In a 2001 report, the Institute of Medicine (IOM) stated that between the health care we now have and the health care we could have lies not just a gap, but a chasm.[3] The IOM identified six dimensions of quality as priorities for healthcare system improvement:

- **Safe**: avoiding injuries to patients from the care that is intended to help them.
- **Effective**: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.
- **Patient centered**: providing care that is respectful of and responsive to individual patient preferences, need, and values, and ensuring that patient values guide all clinical decisions.
- **Timely**: reducing wait time and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** avoiding waste, including waste in equipment, supplies and ideas and energy.
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.[4]

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[1] Midwest Business Group on Health, Reducing the Cost of Poor Quality Healthcare Through Responsible Purchasing Leadership, 2003, www.mbgh.org.
[2] Rand Health, The First National Report Card on Health Care in America, 2006, Santa Monica, CA, www.rand.org.
Napier, Melanie, All Americans at risk of receiving poor quality health care, Robert Wood Johnson Foundation, Research Highlight, Number 1, March 2006.
Asch SA, Kerr EA, Kessey J, Adams J, et al., "Who is at Greatest Risk of Receiving Poor Quality Health Care?" New England Journal of Medicine. 354(11): 1147-1156.
[3] Institute of Medicine, Crossing the Quality Chasm: A New Health Care System for the 21st Century, 2001, p.3, www.iom.edu.
[4] Institute of Medicine, Crossing the Quality Chasm: A New Health Care System for the 21st Century, 2001, p.3, www.iom.edu.

Deficits in health care quality pose a serious threat to the health of Connecticut's residents and come with a huge price tag adding billions in unnecessary health care expenditures. A 2002 study commissioned by the Midwest Business Group on Health estimated that the "cost of poor quality" in the health care system accounts for 30 percent of all health care spending as a result of overuse, misuse and waste.[5] The 30 percent figure does not include the financial impact of under use of health care services in health care spending cost. The cost of poor quality care is passed on to private and public purchasers of health care, consumers, and others in the form of higher fees.

The Business Council of Fairfield County believes that we should stop paying for poor quality of care by requiring health care providers to waive costs associated with serious preventable medical errors, specifically The National Quality Forum's List of 28 Never Events, and agreeing not to seek reimbursement from the patient or third party payers. According to the National Quality Forum (NQF), "never events" are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. These events include: surgery performed on the wrong body part ; surgery performed on the wrong patient; wrong surgical procedure on a patient; and retention of a foreign object in a patient after surgery or other procedure .

More and more states (and some private insurers) are trying to improve quality and cut ever-spiraling health-care costs by not paying for medical errors. States are following in the footsteps of the Centers for Medicare & Medicaid Services (CMS), which in October 2007 announced they would no longer provide Medicare payment for "never events," or egregious hospital errors.[6]

We therefore support the intent of H.B. 1045. However, we believe that Connecticut health care consumers deserve an open and transparent health care system and that hospital specific adverse event reporting is necessary subject to HIPPA requirements. We agree that the data should not be subject to subpoena or discovery or introduced into evidence in any judicial proceeding except as otherwise specifically provided by law.

Thank you for the opportunity to comment.

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[5] Midwest Business Group on Health, Reducing the Costs of Poor Quality Healthcare Through Responsible Purchasing Leadership, 2002, www.mbgh.org

[6] National Council of State Legislatures, "Never Events" Become Ever Present as More States Refuse to Pay for Mistakes , Volume 29, Issue 519 , July 7, 2008, http://www.ncsl.org/programs/health/shn/2008/sn519b.htm